PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2381

(Reference to printed bill)

Strike everything after the enacting clause and insert:

"Section 1. Section 20-2501, Arizona Revised Statutes, is amended to read:

20-2501. Definitions; scope

A. In this chapter, unless the context otherwise requires:

1. "Adverse decision" means EITHER:

(a) A ~~utilization review~~ determination by the utilization review agent that a requested service or claim for service is ~~not a covered service or is not~~ medically necessary under the plan if that determination results in a documented denial or nonpayment of the service or claim.

(b) A COVERAGE-ONLY DETERMINATION THAT A REQUESTED SERVICE OR CLAIM FOR SERVICE IS NOT A COVERED SERVICE UNDER THE PLAN IF THAT DETERMINATION RESULTS IN A DOCUMENTED DENIAL OR NONPAYMENT OF THE SERVICE OR CLAIM.

2. "Benefits based on the health status of the insured" means a contract of insurance to pay a fixed benefit amount, without regard to the specific services received, to a policyholder who meets certain eligibility criteria based on health status including:

(a) A disability income insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who is deemed disabled as defined by the policy terms.

(b) A hospital indemnity policy that pays a fixed daily benefit during hospital confinement.

(c) A disability insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who is certified by a licensed health care professional as chronically ill as defined by the policy terms.

(d) A disability insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who suffers from a prolonged physical illness, disability or cognitive disorder as defined by the policy terms.

3. "Claim" means a request for payment for a service already provided. Claim does not include:

(a) Claim adjustments for usual and customary charges for a service or coordination of benefits between health care insurers.

(b) A request for payment under a policy or contract that pays benefits based on the health status of the insured and that does not reimburse the cost of or provide covered services.

4. "COVERAGE-ONLY" MEANS A DETERMINATION THAT ONLY INVOLVES ISSUES OF COVERAGE AND DOES NOT INCLUDE ISSUES OF MEDICAL NECESSITY.

~~4.~~ 5. "Covered service" means a service that is included in a policy, evidence of coverage or similar document that specifies which services, insurance or other benefits are included or covered.

~~5.~~ 6. "Denial" means a direct or indirect determination regarding all or part of a request for any service or a direct determination regarding a claim that may trigger a request for review or reconsideration. Denial does not include:

(a) Enforcement of a health care insurer's deductibles, copayments or coinsurance requirements or adjustments for usual and customary charges, deductibles, copayments or coinsurance requirements for a service or coordination of benefits between health care insurers.

(b) The rejection of a request for payment under a policy or contract that pays benefits based on the health status of the insured and that does not reimburse the cost of or provide covered services.

~~6.~~ 7. "Department" means the department of insurance.

~~7.~~ 8. "Director" means the director of the department of insurance.

~~8.~~ 9. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, prepaid dental plan organization, medical service corporation, dental service corporation or optometric service corporation or a hospital, medical, dental and optometric service corporation.

~~9.~~ 10. "Indirect denial" means a failure to communicate authorization or nonauthorization to the member by the utilization review agent within ten business days after the utilization review agent receives the request for a covered service.

~~10.~~ 11. "Provider" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for providing care, treatment and services rendered to a patient.

~~11.~~ 12. "Service" means a diagnostic or therapeutic medical or health care service, benefit or treatment.

~~12.~~ 13. "Utilization review":

(a) Means a system for reviewing the appropriate and efficient allocation of inpatient hospital resources, inpatient medical services and outpatient surgery services that are being given or are proposed to be given to a patient, and of any medical, surgical and health care services or claims for services that may be covered by a health care insurer depending on determinable contingencies, including without limitation outpatient services, in-office consultations with medical specialists, specialized diagnostic testing, mental health services, emergency care and inpatient and outpatient hospital services.

(b) INCLUDES COVERAGE-ONLY DETERMINATIONS.

(c) ~~Utilization review~~ Does not include elective requests for the clarification of coverage.

~~13.~~ 14. "Utilization review agent" means a person or entity that performs utilization review. For THE purposes of article 2 of this chapter, utilization review agent has the same meaning prescribed in section 20-2530. For THE purposes of this chapter, utilization review agent does not include:

(a) A governmental agency.

(b) An agent that acts on behalf of the governmental agency.

(c) An employee of a utilization review agent.

~~14.~~ 15. "Utilization review plan" means a summary description of the utilization review guidelines, protocols, procedures and written standards

and criteria ~~of a utilization review agent~~ FOR MEDICAL NECESSITY AND COVERAGE-ONLY DETERMINATIONS.

B. For the purposes of this chapter, utilization review by an optometric service corporation applies only to nonsurgical medical and health care services.

Sec. 2. Section 20-2502, Arizona Revised Statutes, is amended to read:

20-2502. Utilization review activities; exemptions

A. A utilization review agent shall not conduct utilization review in this state unless the utilization review agent meets or is exempt from ~~the provisions of~~ this article.

B. A person is exempt from ~~the provisions of~~ this article if the person:

1. Is accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.

2. Conducts internal utilization review for hospitals, home health agencies, clinics, private offices or other health facilities or entities if the review does not result in the approval or denial of payment for hospital or medical services.

3. Conducts utilization review activities exclusively for work related injuries and illnesses covered under the workers' compensation laws in title 23.

4. Conducts utilization review activities exclusively for a self-funded or self-insured employee benefit plan if the regulation of that plan is preempted by section 514(b) of the employee retirement income security act of 1974~~,~~ (29 United States Code section 1144(b)).

5. AS A HEALTH CARE INSURER OR ON BEHALF OF A HEALTH CARE INSURER CONDUCTS UTILIZATION REVIEW THAT CONSISTS ENTIRELY OF COVERAGE-ONLY DETERMINATIONS.

C. A utilization review agent OR A PERSON WHO IS EXEMPT FROM THIS ARTICLE PURSUANT TO SUBSECTION B, PARAGRAPH 5 OF THIS SECTION shall conduct utilization review in accordance with the agent's utilization review plan

that is on file with the department pursuant to section 20-2505 and in accordance with section 20-2532.

Sec. 3. Section 20-2505, Arizona Revised Statutes, is amended to read:

20-2505. Application for certification

A utilization review agent applying for a certificate shall submit the following information to the department:

1. A signed and notarized application on a form prescribed by the director.

2. A utilization review plan that includes a summary description of review guidelines, protocols and procedures, standards and criteria to be used in MAKING COVERAGE-ONLY DETERMINATIONS AND evaluating inpatient hospital care, inpatient medical care, outpatient surgical care and any medical, surgical and health care services that may be covered by a health care insurer and the provisions by which patients, providers or hospitals may seek reconsideration or appeal of decisions made by the utilization review agent.

3. The professional qualifications of the personnel either employed or under contract to perform the utilization review. Personnel conducting utilization review shall have current licenses that are in good standing and without restrictions from a state health care professional licensing agency in the United States and may be a member of a profession that practices inpatient hospital or outpatient surgical care.

4. A description of the policies and procedures that ensure that a representative of the utilization review agent is available to receive and send the notice and acknowledgments prescribed in article 2 of this chapter and is reasonably accessible to patients and providers in this state and the department by a toll free telephone line or by acceptance of long-distance collect calls for forty hours each week during normal business hours.

5. A description of the policies and procedures that ensure that the utilization review agent will follow applicable state and federal laws to protect the confidentiality of individual medical records.

6. A copy of the materials or a description of the procedure designed to inform patients and providers, as appropriate, of the requirements of the utilization review plan.

Sec. 4. Section 20-2530, Arizona Revised Statutes, is amended to read:

20-2530. Definitions

For the purposes of this article:

1. "Member" means a person who is covered under a health care plan provided by a health care insurer or that person's treating provider, parent, legal guardian, surrogate who is authorized to make health care decisions for that person by a power of attorney, a court order or the provisions of section 36-3231, or agent who is an adult and who has the authority to make health care treatment decisions for that person pursuant to a health care power of attorney.

2. "Utilization review agent" means those persons and entities that perform utilization review as defined in section 20-2501 and includes any health care insurer whose utilization review plan includes the direct or indirect denial of requested medical or health care services or the denial of claims BASED ON EITHER MEDICAL NECESSITY OR COVERAGE-ONLY DETERMINATIONS.

Sec. 5. Section 20-2531, Arizona Revised Statutes, is amended to read:

20-2531. Applicability; requirements

A. Notwithstanding article 1 of this chapter and subject to subsection B of this section, this article applies to all utilization review decisions made by utilization review agents and health care insurers operating in this state.

B. Each utilization review agent and each health care insurer operating in this state whose utilization review system includes the power to affect the direct or indirect denial of requested medical or health care services or claims for medical or health care services BASED ON EITHER MEDICAL NECESSITY OR COVERAGE-ONLY DETERMINATIONS shall adopt written utilization review standards and criteria and processes for the review, reconsideration and appeal of denials that do all of the following:

1. Meet the requirements of this article.

2. Are consistent with chapter 1 of this title.

3. Comply with section 20-2505, paragraphs 2 through 6.

C. This article does not apply to utilization review:

1. Performed under contract with the federal government for utilization review of patients eligible for all services under title XVIII of the social security act.

2. Performed by a self-insured or self-funded employee benefit plan or a multiemployer employee benefit plan created in accordance with and pursuant to 29 United States Code section 186(c) if the regulation of that plan is preempted by section 514(b) of the employee retirement income security act of 1974 (29 United States Code section 1144(b)), but this article does apply to a health care insurer that provides coverage for services as part of an employee benefit plan.

3. Of work related injuries and illnesses covered under the workers' compensation laws in title 23.

4. Performed under the terms of a policy that pays benefits based on the health status of the insured and does not reimburse the cost of or provide covered services.

5. Performed under the terms of a long-term care insurance policy as defined in section 20-1691.

6. Performed under the terms of a medicare supplement policy as defined by the department.

D. This article does not create any new private right or cause of action for or on behalf of any member. This article provides only an administrative process for a member to pursue an external independent review of a denial for a covered service or claim for a covered service.

E. Utilization review activities involving retrospective claims review shall be limited to the provisions of this article only as clearly and specifically provided in the provisions of this article.

Sec. 6. Section 20-2533, Arizona Revised Statutes, is amended to read:

20-2533. Denial; levels of review; disclosure; additional time after service by mail; review process

A. Any member who is denied a covered service or whose claim for a service is denied may pursue the applicable review process prescribed in this article. Except as provided in sections 20-2534 and 20-2535, health care insurers shall provide at least the following levels of review, as applicable:

1. An expedited medical review and expedited appeal pursuant to section 20-2534.

2. An informal reconsideration pursuant to section 20-2535.

3. A formal appeal process pursuant to section 20-2536.

4. An external independent review pursuant to section 20-2537.

B. A health care insurer may offer additional levels of review other than the levels prescribed in subsection A of this section as long as the additional levels of review do not increase the time period limitations prescribed by this article.

C. At the time coverage is initiated, each health care insurer that operates in this state and whose utilization review system includes the power to affect the direct or indirect denial of requested medical or health care services or claims for medical or health care services shall include a separate information packet that is approved by the director with the member's policy, evidence of coverage or similar document. At the time coverage is renewed, each health care insurer shall include a separate statement with the member's policy, evidence of coverage or similar document that informs the member that the member can obtain a replacement packet that explains the appeal process by contacting a specific department and telephone number. A health care insurer shall also provide a copy of the information packet to the member or the member's treating provider on request and to the member within five business days after the date the appeal is initiated pursuant to section 20-2534, 20-2535 or 20-2536. The information packet

provided by the health care insurer shall include all of the following information:

1. A detailed description and explanation of each level of review prescribed in subsection A of this section and notice of the member's right to proceed to the next level of review if the prior review is unsuccessful.

2. An explanation of the procedures that the member must follow, including the applicable time periods, for each level of review prescribed in subsection A of this section and an explanation of how the member may obtain the member's medical records pursuant to title 12, chapter 13, article 7.1.

3. The specific title and department of the person and the address, telephone number and telefacsimile number of that person whom the member must notify at each level of review prescribed in subsection A of this section in order to pursue that level of review.

4. The specific title and department of the person and the address, telephone number and telefacsimile number of the person who will be responsible for processing that review.

5. A notice that if the member decides to pursue an appeal the member must provide the person who will be responsible for processing the appeal with any material justification or documentation for the appeal at the time that the member files the written appeal.

6. A description of the utilization review agent's and health care insurer's roles at each level of review prescribed by subsection A of this section and an outline of the director's role during the external independent review process, if not already described in response to paragraph 1 of this subsection.

7. A notice that if the member participates in the process of review pursuant to this article the member waives any privilege of confidentiality of the member's medical records regarding any person who examined or will examine the member's medical records in connection with that review process for the medical condition under review.

8. A statement that the member is not responsible for the costs of any external independent review.

9. Standardized forms that are prescribed by the department and that a member may use to file and pursue an appeal.

10. The name and telephone number for the department of insurance consumer assistance office with a statement that the department of insurance consumer assistance office can assist consumers with questions about the health care appeals process.

D. At the time of issuing a denial, the health care insurer shall notify the member of the right to appeal under this article. A health care insurer that issues an explanation of benefits document shall satisfy this obligation by prominently displaying in the document a statement about the right to appeal. A health care insurer that does not issue an explanation of benefits document shall satisfy this obligation through some other reasonable means to assure that the member is apprised of the right to appeal at the time of a denial. A reasonable means that includes giving the member's treating provider a form statement about the right to appeal shall require the treating provider to notify the member of the member's right to appeal.

E. Any written notice, acknowledgment, request, decision or other written document required to be mailed pursuant to this article is deemed received by the person to whom the document is properly addressed on the fifth business day after the request is mailed. For the purposes of this subsection, "properly addressed" means the last known address.

F. The director shall require any member who files a complaint with the department relating to an adverse decision to pursue the review process prescribed in this article. This subsection does not limit the director's authority pursuant to chapter 1, article 2 of this title.

G. If the member's complaint is an issue of medical necessity under the coverage document and not ~~whether the claim or service is covered~~ A COVERAGE-ONLY ISSUE, the informal reconsideration shall be performed as prescribed by section 20-2535 by a licensed health care professional. If the member's complaint is an issue of medical necessity under the coverage document and not ~~whether the claim or service is covered~~ A COVERAGE-ONLY ISSUE, the expedited review or formal appeal shall be decided by a physician,

provider or other health care professional as prescribed by section 20-2534 or 20-2536. Any external independent review shall be decided by a physician, provider or other health care professional as prescribed by section 20-2537.

H. Any person given access to a member's medical records or other medical information in connection with proceedings pursuant to this article shall maintain the confidentiality of the records or information in accordance with title 12, chapter 13, article 7.1.

Sec. 7. Section 20-2534, Arizona Revised Statutes, is amended to read:

20-2534. Expedited medical review; expedited appeal

A. Any member who is denied a request for a covered service may pursue an expedited medical review of that denial if the member's treating provider certifies in writing and provides supporting documentation to the utilization review agent that the time period for the informal reconsideration process and formal appeal process prescribed in sections 20-2535 and 20-2536 is likely to cause a significant negative change in the member's medical condition at issue that is subject to the appeal. The treating provider's certification is not challengeable by the health care insurer. A health care insurer whose utilization review activities consist only of claims review for services already provided is not required to provide its members an expedited medical review or expedited appeal pursuant to this section. A health care insurer who conducts utilization review of claims in connection with services already provided is not required to provide its members an expedited medical review or expedited appeal of a claim related to a service already provided.

B. On receipt of the certification and supporting documentation, the utilization review agent has one business day to make a decision and mail to the member and the member's treating provider a notice of that decision, including the criteria used and the clinical reasons for that decision and any references to supporting documentation. If the member's complaint is an issue of medical necessity under the coverage document and not whether the service is covered, before making a decision, the agent shall consult with a physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 17, 19 or 29 or an out of state provider,

physician or other health care professional who is licensed in another state and who is not licensed in this state and who typically manages the medical condition under review.

C. If the utilization review agent affirms the denial of the requested service, the agent shall telephonically provide and mail to the member and the member's treating provider a notice of the adverse decision and of the member's option to immediately proceed to an expedited appeal pursuant to subsection E of this section.

D. At any time during the expedited appeal process, the utilization review agent may request an expedited external independent review ~~process~~ pursuant to section 20-2537. If the utilization review agent initiates ~~the~~ AN expedited external independent review ~~process~~, the utilization review agent does not have to comply with subsection E of this section.

E. If the member chooses to proceed with an expedited appeal, the member's treating provider shall immediately submit a written appeal of the denial of the service to the utilization review agent and provide the utilization review agent with any additional material justification or documentation to support the member's request for the service. Within three business days after receiving the request for an expedited appeal, the utilization review agent shall provide notice of the expedited appeal decision as prescribed in this subsection. If the member's complaint is an issue of medical necessity under the coverage document and not ~~whether the service is covered~~ A COVERAGE-ONLY ISSUE, any provider, physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out of state provider, physician or other health care professional who is licensed in another state and who is not licensed in this state, who is employed or under contract with the utilization review agent and who is qualified in a similar scope of practice as a provider, physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out of state provider, physician or other health care professional who is licensed in another state and who is not licensed in this state and who

typically manages the medical condition under appeal shall review the expedited appeal and render a decision based on the utilization review plan adopted by the utilization review agent. Pursuant to the requirements of this subsection, the utilization review agent shall select the provider, physician or other health care professional who shall review the appeal and render the decision. If the utilization review agent, provider, physician or other health care professional denies the expedited appeal, the utilization review agent shall telephonically provide and mail to the member and the member's treating provider a notice of the denial and of the member's option to immediately proceed to the external independent review prescribed in section 20-2537.

F. If the utilization review agent, provider, physician or other health care professional concludes that the covered service should be provided, the health care insurer is bound by the utilization review agent's decision.

Sec. 8. Section 20-2536, Arizona Revised Statutes, is amended to read:

20-2536. Formal appeal

A. After any applicable informal reconsideration pursuant to section 20-2535, if the utilization review agent denies the member's request for a covered service, the member may appeal that adverse decision. The member shall mail a written appeal to the utilization review agent within sixty days after receipt of the adverse decision. In the event of a denial of a claim for a service that has already been provided, the member may appeal that denial by filing a written appeal with the utilization review agent within two years after receipt of the notice of the denial.

B. The utilization review agent shall mail a written acknowledgment to the member and the member's treating provider within five business days after the agent receives the formal appeal.

C. The member or the member's treating provider shall submit to the utilization review agent with the written formal appeal any material justification or documentation to support the member's request for the service or claim for a service.

D. If the member's complaint is an issue of medical necessity under the coverage document and not ~~whether the service is covered~~ A COVERAGE-ONLY ISSUE, a provider, physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out of state provider physician or other health care professional who is licensed in another state and who is not licensed in this state, who is employed or under contract with the utilization review agent and who is qualified in a similar scope of practice as a provider, physician or other health care professional licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out of state provider, physician or other health care professional who is licensed in another state and who is not licensed in this state and who typically manages the medical condition under appeal shall review the appeal and render a decision based on the utilization review plan adopted by the utilization review agent. Pursuant to the requirements of this subsection, the utilization review agent shall select the provider, physician or other health care professional who shall review the appeal and render the decision.

E. Except as provided in subsection F of this section, the utilization review agent has:

1. With respect to adverse decisions relating to services that have not been provided, up to thirty days after receipt of the written appeal to notify the member in writing of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.

2. With respect to denials relating to claims that have already been provided, up to sixty days after receipt of the written appeal to notify the member in writing of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.

F. At any time during the formal appeal process, the utilization review agent may request an external independent review process pursuant to section 20-2537. If the utilization review agent initiates the external independent review process, the utilization review agent does not have to comply with subsection E of this section.

G. If at the conclusion of the formal appeal process the utilization review agent denies the appeal and the utilization review agent does not initiate the external independent review process, the utilization review agent shall provide the member with notice of the option to proceed to an external independent review pursuant to section 20-2537.

H. If the utilization review agent concludes that the covered service should be provided or the claim for a covered service should be paid, the health care insurer is bound by the utilization review agent's decision.

Sec. 9. Section 20-2537, Arizona Revised Statutes, is amended to read:

20-2537. External independent review; expedited external independent review

A. If the utilization review agent denies the member's request for a covered service or claim for a covered service at both the informal reconsideration level and the formal appeal level, or at the expedited medical review level, the member may initiate an external independent review.

B. Except as provided in subsection K of this section, within thirty days after the member receives written notice by the utilization review agent of the adverse decision made pursuant to section 20-2534 or 20-2536, if the member decides to initiate an external independent review, the member shall mail to the utilization review agent a written request for an external independent review, including any material justification or documentation to support the member's request for the covered service or claim for a covered service.

C. Except as provided in subsection K of this section, within five business days after the utilization review agent receives a request for an external independent review from the member pursuant to subsection B of this section or the director pursuant to subsection G of this section, or if the utilization review agent initiates an external independent review pursuant to section 20-2536, subsection F, the utilization review agent shall:

1. Mail a written acknowledgment to the director, the member, the member's treating provider and the health care insurer.

2. Forward to the director the request for review, the terms of agreement in the member's policy, evidence of coverage or a similar document and all medical records and supporting documentation used to render the decision pertaining to the member's case, a summary description of the applicable issues including a statement of the utilization review agent's decision, the criteria used and the clinical reasons for that decision, the relevant portions of the utilization review agent's utilization review plan and the name and credentials of the licensed health care provider who reviewed the case as required by section 20-2533, subsection G.

D. Except as provided in subsection K of this section, within five days after the director receives all of the information prescribed in subsection C, paragraph 2 of this section and if the case involves an issue of medical necessity under the coverage document, the director shall choose an independent review organization procured pursuant to section 20-2538 and forward to the organization all of the information required by subsection C, paragraph 2 of this section.

E. Except as provided in subsection K of this section, for cases involving an issue of medical necessity under the coverage document, within twenty-one days after the date of receiving a case for independent review from the director, the independent review organization shall evaluate and analyze the case and, based on all information required under subsection C, paragraph 2 of this section, render a decision that is consistent with the utilization review plan on whether or not the service or claim for the service is medically necessary and send the decision to the director. Within five business days after receiving a notice of decision from the independent review organization, the director shall mail a notice of the decision to the utilization review agent, the health care insurer, the member and the member's treating provider. The decision by the independent review organization is a final administrative decision pursuant to title 41, chapter 6, article 10 and is subject to judicial review pursuant to title 12, chapter 7, article 6. The health care insurer shall provide any service or pay any claim determined to be covered and medically necessary by the independent

review organization for the case under review regardless of whether judicial review is sought.

F. Except as provided in subsection K of this section, for cases involving ~~an issue of coverage~~ A COVERAGE-ONLY ISSUE, within fifteen business days after receipt of all of the information prescribed in subsection C, paragraph 2 of this section from the utilization review agent, the director shall determine if the service or claim is or is not covered and if the adverse decision made pursuant to section 20-2536 conforms to the utilization review agent's utilization review plan and this article and shall mail a notice of determination to the utilization review agent, the health care insurer, the member and the member's treating provider.

G. If the director finds that the case involves a medical issue or is unable to determine ~~issues of coverage~~ COVERAGE-ONLY ISSUES, the director shall submit the member's case to the external independent review organization in accordance with subsections E and K of this section.

H. After a decision is made pursuant to subsection E, F, G or K of this section, the reconsideration, appeal and administrative processes are completed and the department's role is ended, except:

1. To transmit, when necessary, a record of the proceedings to superior court or to the office of administrative hearings.

2. To issue a final administrative decision pursuant to section 41-1092.08.

I. Except as provided in subsection K of this section, on written request by the independent review organization, the member or the utilization review agent, the director may extend the twenty-one day time period prescribed in subsection E of this section for up to an additional thirty days if the requesting party demonstrates good cause for an extension.

J. A decision made by the director or an independent review organization pursuant to this section is admissible in proceedings involving a health care insurer or utilization review agent.

K. If the utilization review agent denies the member's request for a covered service or claim for a covered service at the expedited medical

review level presented and resolved pursuant to section 20-2534, subsections A and E, the member may initiate an expedited external independent review in accordance with the following:

1. Within five business days after the member receives written notice by the utilization review agent of the adverse decision made pursuant to section 20-2534, if the member decides to initiate an EXPEDITED external independent review, the member shall mail to the utilization review agent a written request for an expedited external independent review, including any material justification or documentation to support the member's request for the covered service or claim for a covered service.

2. Within one business day after the utilization review agent receives a request for an EXPEDITED external independent review from the member pursuant to this subsection or if the utilization review agent initiates an EXPEDITED external independent review pursuant to section 20-2534, subsection D, the utilization review agent shall:

(a) Mail a written acknowledgment to the director, the member, the member's treating provider and the health care insurer.

(b) Forward to the director the request for an expedited independent external review, the terms of agreement in the member's policy, evidence of coverage or a similar document and all medical records and supporting documentation used to render the decision pertaining to the member's case, a summary description of the applicable issues including a statement of the utilization review agent's decision, the criteria used and the clinical reasons for that decision, the relevant portions of the utilization review agent's utilization review plan and the name and credentials of the licensed health care provider who reviewed the case as required by section 20-2534, subsection B.

3. Within two business days after the director receives all of the information prescribed in this subsection and if the case involves an issue of medical necessity, the director shall choose an independent review organization procured pursuant to section 20-2538 and forward to the organization all of the information required by this subsection.

4. For cases involving an issue of medical necessity, within five business days from the date of receiving a case for expedited external independent review from the director, the independent review organization shall evaluate and analyze the case and, based on all information required under subsection C, paragraph 2 of this section, render a decision that is consistent with the utilization review plan on whether or not the service or claim for the service is medically necessary and send the decision to the director. Within one business day after receiving a notice of decision from the independent review organization, the director shall mail a notice of the decision to the utilization review agent, the health care insurer, the member and the member's treating provider. The decision by the independent review organization is a final administrative decision pursuant to title 41, chapter 6, article 10 and, except as provided in section 41-1092.08, subsection H, is subject to judicial review pursuant to title 12, chapter 7, article 6. The health care insurer shall provide any service or pay any claim determined to be covered and medically necessary by the independent review organization for the case under review regardless of whether judicial review is sought.

5. For cases involving ~~an issue of coverage~~ A COVERAGE-ONLY ISSUE, within two business days after receipt of all of the information prescribed in subsection C of this section from the utilization review agent, the director shall determine if the service or claim is or is not covered and if the adverse decision made pursuant to section 20-2534 conforms to the utilization review agent's utilization review plan and this article and shall mail a notice of determination to the utilization review agent, the health care insurer, the member and the member's treating provider.

L. Notwithstanding title 41, chapter 6, article 10 and section 12-908, if a party to a decision issued under this section seeks further administrative review, the department shall not be a party to the action unless the department files a motion to intervene in the action.

M. The independent review organization, the director or the office of administrative hearings may not order the health care insurer to provide a

service or to pay a claim for a benefit or service that is excluded from coverage by the contract.

N. The health care insurer shall provide any service or pay any claim determined in a final administrative decision to be covered and medically necessary for the case under review regardless of whether judicial review is sought. Any proceedings before the office of administrative ~~proceedings~~ HEARINGS that involve an expedited external independent review and that are subject to subsection K of this section shall be promptly instituted and completed."

Amend title to conform

NANCY MCLAIN

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02/19/2009
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